Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address
VISTA MEDICAL CENTER HOSPITAL
4301 VISTA ROAD
PASADENA TX 77504

Carrier's Austin Representative Box
#45

MFDR Date Received
JULY 18, 2005

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

MFDR Tracking Number
M4-06-3938-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Taken From the Table of Disputed Services: "R-Carrier has pre-authorized treatment without proper notice of compensability/extent of injury dispute. Healthcare Provider is unaware of any PLN-11 (TWCC-21) denial filed by Carrier regarding the above-referenced claim….Carrier did not make payment allowed in their own EOB."

Requestor's Supplemental Position Summary Dated February 15, 2013: "According to the Third Court of Appeals' opinion, a provider is entitled to reimbursement under the 'Stop Loss' exception in the Acute Care Inpatient Hospital Fee Guideline if the audited billed charges exceed $40,000 and if the surgery(ies) preformed on the claimant were unusually extensive and unusually costly…When these elements are proven, then the provider is entitled to be paid 75% of its billed charges. The medical records on file with MDR and the additional records attached hereto, show this admission to be a complex spine surgery, specifically a bilateral hemilaminotomies at L4-5 and L5-S1, bilateral partial foraminotomies at L4-5 and L5-S1 and an external neurolysis at L5 nerve root. This complex spine surgery is unusually extensive for at least two reasons: first, Medicare's length of stay for this DRG is 2 days and the median length of state for workers' compensation inpatient admissions is three days, whereas the length of stay for this admission of 5 days, exceeds both the Medicare LSO and the median LOS for workers' compensation; and second, the patient post-operatively developed several complications included: severe muscle spasms and breathing issues due to asthma requiring numerous albuterol treatments throughout the stay. The medical and billing records on file with MDR and additional records attached hereto, also show that this admission was unusually costly as this procedure required two scrub techs, two circulating nurses and an assistant, which resulted in additional costs above the norm and the need for a cell save during the procedure. In addition, due to the patient's extended length of stay, additional resources were utilized to manage patient's care. Therefore, reimbursement should be in an amount which is 75% of billed charges when is $42,185.69…The Carrier made a payment of $6,169.02. Therefore, the Carrier should be ordered to pay Provider the additional amount of $36,016.67, plus any and all applicable interest."

Amount in Dispute: $36,016.67

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated July 21, 2005: "The office will allow reimbursement per the per diem guidelines as no documentation attached to support the stop-loss methodology."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
July 29, 2004 through August 3, 2004	Inpatient Hospital Services	$36,016.67	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
3. 28 Texas Administrative Code §134.1, 27 *Texas Register* 4047, effective May 16, 2002, sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of a contract or an applicable division fee guideline.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits
- R3 – TWCC CODE: R – EXTENT OF INJURY
- Charge(s) unrelated to the compensable injury
- 506 – Re-evaluated bill, payment adjusted
- 520 – Inpatient Surgical Per Diem Allowance
- W1 – Workers' Compensation State Fee Schedule Adj
- 510 – Payment Determined
- 601 – Non-Physician provider reimbursed @ 75%
- W10 – Payment based on fair & reasonable methodology

Issues

1. Does the submitted documentation support that an extent of injury issue exists in this dispute?
2. Did the audited charges exceed $40,000.00?
3. Did the admission in dispute involve unusually extensive services?
4. Did the admission in dispute involve unusually costly services?
5. Is the requestor entitled to additional reimbursement?

Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 Texas Register 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original MDR submission, position or response as applicable. The division received supplemental information as noted in the position summaries above. The supplemental information was shared among the parties as appropriate. The documentation filed by the requestor and respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the division will address whether the total audited charges ***in***

this case exceed $40,000; whether the admission and disputed services ***in this case*** are unusually extensive; and whether the admission and disputed services ***in this case*** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that "Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection…" 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. According to the original explanation of benefits, the respondent initially denied reimbursement for the disputed services based upon reason code "R." Upon reconsideration, the respondent did not maintain this denial reason and issued payment of $6,169.02 per the fee guideline. Therefore, an extent of injury issue does not exist in this dispute.

2. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "…to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000, the minimum stop-loss threshold." Furthermore, (A) (v) of that same section states "…Audited charges are those charges which remain after a bill review by the insurance carrier has been performed…" Review of the explanation of benefits issued by the carrier finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal $56,247.58. The Division concludes that the total audited charges exceed $40,000.

3. The requestor asserts that "According to the Third Court of Appeals' opinion, a provider is entitled to reimbursement under the 'Stop Loss' exception in the Acute Care Inpatient Hospital Fee Guideline if the audited billed charges exceed $40,000 and if the surgery(ies) preformed on the claimant were unusually extensive and unusually costly…When these elements are proven, then the provider is entitled to be paid 75% of its billed charges." As noted above, the Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) rendered judgment to the contrary. In its supplemental position statement, the requestor considered the Courts' final judgment and opined on both rule requirements. In regards to whether the services were unusually extensive, the Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually extensive services. Rule §134.401(c)(2)(C) allows for payment under the stop-loss exception on a case-by-case basis only if the particular case exceeds the stop-loss threshold as described in paragraph (6). Paragraph (6)(A)(ii) states that "This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission." The requestor's supplemental position statement asserts that:

   > "The medical records on file with MDR and the additional records attached hereto, show this admission to be a complex spine surgery, specifically a bilateral hemilaminotomies at L4-5 and L5-S1, bilateral partial foraminotomies at L4-5 and L5-S1 and an external neurolysis at L5 nerve root. This complex spine surgery is unusually extensive for at least two reasons: first, Medicare's length of stay for ths DRG is 2 days and the median length of state for workers' compensation inpatient admissions is three days, whereas the length of stay for this admission of 5 days, exceeds both the Medicare LSO and the median LOS for workers' compensation; and second, the patient post-operatively developed several complications included: severe muscle spasms and breathing issues due to asthma requiring numerous albuteral treatments throughout the stay."

   The requestor did not submit documentation to support the reasons asserted, nor did the requestor point to any sources for the information presented. The reasons stated are therefore not demonstrated. Additionally, the requestor's position that all spinal surgeries are unusually extensive does not satisfy §134.401(c)(2)(C) which requires application of the stop-loss exception on a case-by-case basis. The Third Court of Appeals' November 13, 2008 opinion affirmed this, stating "The rule further states that independent reimbursement under the Stop-Loss Exception will be 'allowed on a case-by-case basis.' *Id.* §134.401(c)(2)(C). This language suggests that the Stop-Loss Exception was meant to apply on a case-by-case basis in relatively few cases." The requestor's position fails to meet the requirements of §134.401(c)(2)(C) because the particulars of the services in dispute are not discussed, nor does the requestor demonstrate how the services in dispute were unusually extensive in relation to similar spinal surgery services or admissions. For the reasons stated, the division finds that the requestor failed to demonstrate that the services in dispute were unusually extensive.

4. In regards to whether the services were unusually costly, the Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually costly services. 28 Texas Administrative Code §134.401(c)(6) states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The requestor's supplemental position statement asserts that:

"The medical and billing records on file with MDR and additional records attached hereto, also show that this admission was unusually costly as this procedure required two scrub techs, two circulating nurses and an assistant, which resulted in additional costs above the norm and the need for a cell save during the procedure. In addition, due to the patient's extended length of stay, additional resources were utilized to manage patient's care."

The requestor asserts that the resources used for this surgery and admission added substantially to the cost. The requestor does not list or quantify the costs associated with these resources in relation to the disputed services, nor does the requestor provide documentation to support a reasonable comparison between the resources required for this surgery and other similar surgeries. Therefore, the requestor fails to demonstrate that the resources used in this particular admission are unusually costly when compared to resources used in other types of surgeries.

5. For the reasons stated above the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements.* The Division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.

   - Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of $1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission…" The length of stay was five days. The surgical per diem rate of $1,118 multiplied by the length of stay of five days results in an allowable amount of $5,590.00.
   - 28 Texas Administrative Code §134.401(c)(4)(B) allows that "When medically necessary the following services indicated by revenue codes shall be reimbursed at a fair and reasonable rate: (iv) Blood (revenue codes 380-399)." A review of the submitted hospital bill finds that the requestor billed $299.00 for revenue code 391-Blood/Storage Processing. 28 Texas Administrative Code §133.307(g)(3)(D), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought for revenue code 391 would be a fair and reasonable rate of reimbursement. Additional payment cannot be recommended.
   - 28 Texas Administrative Code §134.401(c)(4)(C) states "Pharmaceuticals administered during the admission and greater than $250 charged per dose shall be reimbursed at cost to the hospital plus 10%. Dose is the amount of a drug or other substance to be administered at one time." A review of the submitted itemized statement finds that the requestor billed $302.85/unit for Thrombin 5,000 unit, and $289.00/unit for Dilaudid PCA 100ML. The requestor did not submit documentation to support what the cost to the hospital was for these items billed under revenue code 250. For that reason, additional reimbursement for these items cannot be recommended.

   The division concludes that the total allowable for this admission is $5,590.00. The respondent issued payment in the amount of $6,169.02. Based upon the documentation submitted, no additional reimbursement can be recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed $40,000, but failed to demonstrate that the disputed inpatient hospital admission involved unusually extensive services, and failed to demonstrate that the services in dispute were unusually costly. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount,* and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in no additional reimbursement.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		05/22/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.